Filing at a Glance

Company:	UnitedHealthcare Insurance Company
Product Name:	MIB Authorization
State:	Arkansas
TOI:	ML02 Multi-Line - Other
Sub-TOI:	ML02.000 Multi-Line - Other
Filing Type:	Form
Date Submitted:	11/06/2012
SERFF Tr Num:	UHLC-128757790
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Adamowicz Sue
Reviewer(s):	Linda Bird (primary), Rosalind Minor
Disposition Date:	11/06/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *UnitedHealthcare Insurance Company*
TOI/Sub-TOI: *ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*
Product Name: *MIB Authorization*
Project Name/Number: *UHC 2012/*

General Information

Project Name: UHC 2012
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association
Filing Status Changed: 11/06/2012
State Status Changed: 11/06/2012
Created By: Adamowicz Sue
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Adamowicz Sue

Filing Description:

On behalf of UnitedHealthcare Insurance Company, we are submitting the enclosed Authorization and Acknowledgement form to replace current text on our Life, Disability Income, and Critical Illness applications.

As you may know, the Medical Information Bureau advised member companies of their requirement to add a disclosure sentence to authorization forms. Our primary intent was to add the following sentence, “I authorize UnitedHealthcare, or its reinsurers, to make a brief report of my personal health information to MIB.”

Since we had to update the form for MIB, we took this as an opportunity to make additional improvements. A synopsis of changes follows:

1. We moved the pre-existing disclosure (when applicable) closer to the signature line;
2. We tweaked the description of entities from whom we would obtain information, such as adding "pharmacy benefit manager;"
3. We added text that statements should be true and complete, but are representations and not warranties;
4. We added text about disclosures of the information to others including the MIB;
5. We added that signing is voluntary;
6. We added acknowledgement text for any notices that accompany the form.

Upon approval, this form will replace the authorization text of the current forms for new groups and for existing business as forms are reprinted and/or reissued. The forms affected are:

- EECIAPP-AUTH
- EOI-UHIC-S (7/04)
- EOI-UHIC-L (7/04)
- UEOI (05/03)

Company and Contact

Filing Contact Information

Sue Adamowicz, Compliance Consultant
185 Asylum St
Hartford, CT 06103

Sue_Adamowicz@uhc.com
860-702-6003 [Phone]

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Filing Company Information

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation: $50 per form
Per Company: No

Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company	$50.00	11/06/2012	64607100

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2012	11/06/2012

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Disposition

Disposition Date: 11/06/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement	Approved-Closed	Yes
Supporting Document	Address Change Endorsement	Approved-Closed	Yes
Form	Authorization and Acknowledgement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GRP-AUTH-UHIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/06/2012	Authorization and Acknowledgement	GRP-AUTH-UHIC	AEF	Initial		50.100	MIB Authorization 9-17-UHIC.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Section 8.] AUTHORIZATION AND ACKNOWLEDGEMENT

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health [or that of my Dependents,] to disclose the information to: the UnitedHealthcare Insurance Company; and, its affiliates ("UnitedHealthcare"). This information will be used to determine my eligibility for benefits.

I authorize UnitedHealthcare to: obtain; use; and disclose; my [and my Dependent's] medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize UnitedHealthcare to disclose the information to the Policy's administrator; or as may be required by law. I authorize UnitedHealthcare, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying UnitedHealthcare in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right UnitedHealthcare has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires [24 months] after the date it is signed. [I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.]

[I request the indicated group coverage for myself and, if applicable, for my dependents.] I have not given the agent; or, any other persons any health information not included on this form. I understand that UnitedHealthcare is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on [this] application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; [this] completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that [, subject to the Deferred Effective Date provisions,] coverage will not take effect until UnitedHealthcare grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with [this] application. [I understand that the Policy does not cover disability that begins during the first *insert # of months* after the issue date on account of: a disease; or, physical condition; that I now have or have had in the past.]

[_____ _____

Signature of Applicant Date]

[Return form to:
Group Medical Underwriting Services
PO Box 17829
Portland ME 04112-8829

Fax: 855-290-5224
Email: eoi_underwriting@uhc.com]

Form GRP-AUTH-UHIC [Tracking Number / Barcode]
Printed in U.S.A.

{Note: When this form is added to an application, the statutory fraud warning notices referenced above will follow here.}

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Supporting Document Schedules

		Item Status:	**Status Date:**
Bypassed - Item:	Name Change Endorsement	Approved-Closed	11/06/2012
Bypass Reason:	Not applicable to this filing.		

		Item Status:	**Status Date:**
Bypassed - Item:	Address Change Endorsement	Approved-Closed	11/06/2012
Bypass Reason:	Not applicable to this filing		